Bureau of TennCare

Policy Manual

Policy No: PRO 08-01	
Subject: Seeking Payment from a TennCare Enrollee	
Approval:	**Date:** 1/14/2008

PURPOSE: The purpose of this policy statement is to clarify the circumstances in which providers may seek payment from TennCare enrollees. This policy supersedes TSOP 014 and 014A.

DISCUSSION:

Specific circumstances in which providers may seek payment from an enrollee are identified in State Rules 1200-13-13-.08 and 1200-13-14-.08. Providers who participate in TennCare, even if they do not participate in the enrollee's health plan, are prohibited from seeking payment from enrollees except as described in these rules.

In general, there are two situations when enrollees may have some payment obligations for the services they receive. One situation is when the service carries a copay for the particular enrollee, and the other situation is when the service is non-covered.

1. **Copays.** Certain TennCare Medicaid and TennCare Standard enrollees have copay obligations. These are outlined in State Rules 1200-13-13-.01(22), 1200-13-13-.05, 1200-13-14-.01(21) and 1200-13-14-.05.

2. **Non-covered services.** There are some services that are not covered by TennCare and are not, therefore, services for which a provider may be reimbursed by an MCC. Services that are not covered by TennCare include:
   - Services not included in the list of covered services provided in State Rules at 1200-13-13-.04 and 1200-13-14-.04

- Services specifically identified as non-covered in State Rules 1200-13-13-.10 and 1200-13-14-.10
- Services that are in excess of a benefit limit that an enrollee has reached (benefit limits are stated in State Rules 1200-13-13-.04 and 1200-13-14-.04)
- Services that are not covered because the enrollee was not eligible for TennCare on the date that the service was delivered.

POLICY:

When the enrollee is unable or unwilling to make his copay, TennCare's policy is as follows:

- For Medicaid enrollees, "providers shall not deny services for Medicaid enrollees' failure to make copayments." [Rule 1200-13-13-.08(11)]
- For TennCare Standard enrollees, "Providers may not refuse to deliver a covered service to an enrollee because of the enrollee's failure or inability to make his copay." [Rule 1200-13-14-.05(4)(d)]

When the enrollee has requested a non-covered service, TennCare's policy is that the provider may bill for the non-covered service if the conditions outlined in State Rules 1200-13-13-.08(5) and 1200-13-14-.08(5) are met. There are special rules regarding billing practices when an enrollee has reached a benefit limit. These rules are presented in State Rules 1200-13-13-.08(5) and 1200-13-14- .08(5).

There is one special situation that is addressed in the "Exclusions" rules (1200-13-13-.10 and 1200-13-14-.10). When the enrollee has third party coverage but refuses to comply with the requirements of the third party carrier, the particular item or service he received may be considered "non-covered" by TennCare. Included in the list of items and services that are not covered under the TennCare program are "items or services to the extent that Medicare or a third party is legally responsible to pay or would have been legally responsible to pay except for the enrollee's or the treating provider's failure to comply with the requirements of coverage of such services. [Rule 1200-13-13.10(1)(o), Rule 1200-13-14-.10(1)(o).]

Other special circumstances are listed below:

1. **When the enrollee has other insurance that requires copays.** If an enrollee has other insurance that requires copayments, providers may only bill the enrollee for the copayment permitted by TennCare for services that are covered by TennCare.

   Example: *Johnny Brown is enrolled in TennCare Medicaid. He has insurance that enables him to visit his pediatrician for a copay of $10 per visit. Johnny's TennCare*

exempts him from copays. Therefore, he is entitled to get the service without paying the $10 copay. If the MCC cannot make arrangements to pay the $10 copay so that the provider can bill the third party carrier for the remainder of the cost of the visit, then the MCC may be in the position of having to pay for the service itself.

2. **When a covered service is delivered in a hospital Emergency Department (ED).** Enrollees who present to EDs are assessed to determine whether they need urgent or emergent care. If urgent or emergent care is not needed, the enrollee may be referred to another type of provider, such as his primary care provider (PCP) or an outpatient clinic for treatment. If the enrollee elects to be treated in the ED despite the absence of an urgent or emergent condition and the ED elects to treat the enrollee in such a circumstance, the enrollee can only be charged the copay that is applicable for his TennCare eligibility category. He cannot be charged for the services as a "non-covered service," since the services would be covered in an alternative setting.

3. **Financial responsibility statements.** In order to meet the requirement that a provider informed an enrollee prior to delivering a non-covered service that the service was non-covered, the provider may choose to use a financial responsibility statement. Any acknowledgement of financial responsibility statement must be written at a 6th grade level or less and a copy given to the enrollee. This statement does not need to be approved by TennCare prior to use.

   A provider cannot request or demand that a TennCare enrollee sign a financial responsibility statement making them responsible for payment of a TennCare covered service even if the claim is denied by the MCC.

4. **Definition of "enrollee." "**Enrollee" is defined in TennCare rules 1200-13-13-.01 and 1200-13-14-.01. For the purposes of this policy, an enrollee shall include the patient's "responsible parties" (parent(s), spouses, children and guardians) as defined in Tennessee Code Annotated (TCA) 71-5-103(10). Attempts to bill the patient's parents, as an example, are treated the same as attempts to bill the patient himself.

OFFICES OF PRIMARY RESPONSIBILITY:
TennCare Office of Networks
Provider Networks Department

REFERENCES:
TennCare Medicaid Rule 1200-13-13-.08, .04, .05, .10
TennCare Standard Rule 1200-13-14-.08, .04, .05, .10
TennCare General Rule 1200-13-1-.04

42 CFR 447.20; 447.50-58;
Deficit Reduction Act Chapter 4, Sec. 6041(d)(2)
TCA 71-5-103(10)

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